Michigan Department of Military & Veterans Affairs
Michigan Veterans Homes

APPLICATION FOR ADMISSION
FOR THE GRAND RAPIDS HOME FOR VETERANS

3000 Monroe Ave. NW, Grand Rapids, MI 49505-3397

Thank you for your interest in the Grand Rapids Home for Veterans. Your application will be given *immediate* attention.
You can help the application process by submitting the following documents or information with your application.

Medical

□ Medical history and physical exam of the applicant within the past 90 days. (Required) Must use attachment #2

□ Chest x-ray report of applicant within the past 30 days. (Required)

Documents

□ DD-214 (Report of Separation, Military Record of Service or Enlistment Record.) For help obtaining this record please contact MI Veterans Trust Fund in Lansing for help (517) 284-5299 or the contact the county where the veteran resided at the time of discharge from service. www.archives.gov/research_room/vetrecs

□ Copy of Social Security Card.

□ Marriage certificate copy if currently married.

□ Divorce papers or death certificate for all prior marriages of either the veteran or spouse if currently married.

□ Widow(er) needs to submit marriage certificate and veteran's death certificate.

□ For applicants with dependents, please fill out attachment #1.

□ Birth certificates for all minor children being claimed as dependents.

□ If applicable: Guardianship paper, Conservatorship paper, Power of Attorney, Durable Power of Attorney, Patient Advocate form.

Insurance Information

□ Copies of insurance cards (front and back), including Medicare, Medicaid and secondary insurance if applicable.

□ Copy of nursing care insurance policy if applicable.

Financial

□ Verification of income and assets. This includes copies of any current bank account statements, land contracts, Social Security or other pension award letters or checks.

□ **Call the Member Income and Assessment Office (616) 364-5382 to get an estimate of your projected monthly room and board assessment.** See Computation of Fees sheet for more information.

Taxes

□ Must supply a copy of the past three year's Federal Income Tax forms if filed.

Funeral Arrangement

□ Copies of any prepaid funeral arrangement papers.

Wheelchair Rental

If renting a wheelchair, check with your rental company to see if the insurance company will continue to cover the wheelchair after admission to a veterans' facility. (GRHV can provide a wheelchair after admission)

After the application is received, it is reviewed for completeness, eligibility and level of care. The applicant (or interested other party) will be notified by the Admissions Office to schedule an admission date and time, indicate placement on the waiting list or advise you if we are unable to meet the needs required.

At the time of admission, you will be asked to sign a Member Contract. The purpose of this contract is to outline your financial responsibility required to the Grand Rapids Home for Veterans for your cost of care, Supplementary Services and Member Rights & Responsibilities. **If you would like a copy of this contract prior to admission, please call us at 616-364-5382.**

If you have any questions or wish to know the status of your application, please call: Admissions: 1-844-711-7986 or e-mail: DMVA-Admissions@michigan.gov
Member Finance: (616) 364-5382
VA Benefits: (616) 364-5357
Fax: (616) 364-5373

Grand Rapids Home for Veterans
3000 Monroe Ave NE
Grand Rapids, MI 49505
Phone: (616) 364-5389
Toll Free: 1-844-711-7986
Fax: (616) 364-5373

Michigan Department of Military
& Veterans Affairs
Michigan Veterans Homes

APPLICATION FOR ADMISSION

D.J. Jacobetti Home for Veterans
425 Fisher Street
Marquette, MI 49855
Phone: (906) 226-3576
Toll Free: (800) 433-6760
Fax: (906) 226-2380

Today's Date:	Filing Status: ☐ Veteran ☐ Non-Veteran

APPLICANT INFORMATION

Name of Applicant (Last, First, Middle)	Sex (M/F)	Birth Date

Birth Place (City, State)	Social Security Number

Is this your legal name? ☐ Yes ☐ No If no, what is your legal (former) name?	Have you ever been a resident of either facility? ☐ Yes ☐ No If yes, enter date:

Permanent Address -Street & Number	City	County	State	Zip Code	Phone ( )

Temporary Address -Street & Number	City	County	State	Zip Code	Phone ( )

Race/Ethnicity: ☐ Caucasian/White ☐ Hispanic-American/Latino ☐ Asian Pacific Islander
☐ African-American/Black ☐ Native American/Alaskan-American

Referral Source ☐ Self ☐ Family ☐ Hospital* ☐ Nursing Home*

* Name of Facility _____ Phone Number _____

* Person Referring _____ Title _____

Marital Status: ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

If married or widowed, please complete the following:

Spouse's Name (maiden)	Date/County of Marriage	Date of Birth	Date of Death

If married and either applicant or spouse had prior marriage, please complete (attach extra page if needed):
How many times have you (applicant) been married before? ____ How many times has your current spouse been married before? ____

Check one:	When were you married?	Where were you married? (city/state or county)	Who were you married to? (first, middle initial, last)	When did your marriage end?	Where did your marriage end? (city/state or county)
☐ Applicant ☐ Spouse	____/____/_____			_____/_____/_____ ☐ Death ☐ Divorce	
☐ Applicant ☐ Spouse	____/____/_____			_____/_____/_____ ☐ Death ☐ Divorce	

Line below is for office use only:

Member Number	Level of Care	1 Domiciliary 2 Nursing 3 Special-Alzheimer's 4 Special-Main-1 Courtyard	Present Location					Admission Date		
			Bldg.	Floor	Room Area	No.	Bed			

APPLICANT INFORMATION, Continued

Religious Preference

Father's Full Name	Mother's Full Maiden Name
☐ Living ☐ Deceased	☐ Living ☐ Deceased

Number of Living Children _____ (Please list below)

Name	Age	Street & Number	City	State	Zip	Phone

Do you have a advanced directive or some other document directing medical care/decisions? □ No □ Yes (please provide document)

EMERGENCY CONTACT INFORMATION/RESPONSIBLE PARTY

Responsible Party Name	Relationship to Applicant	E-Mail Address	
Street Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Cell Phone Number	
Emergency Contact Name	Relationship to Applicant	E-Mail Address	
Street Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Cell Phone Number	
Secondary Contact Name	Relationship to Applicant	E-Mail Address	
Street Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Cell Phone Number	
Third Contact Name	Relationship to Applicant	E-Mail Address	
Street Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Cell Phone Number	

FUNERAL ARRANGEMENTS

Funeral Home Preference (Name and Address)

Are Prepaid Arrangements Made? ☐ Yes ☐ No (Please provide a copy.)

Cemetery Preference (Name and Address)

Are Prepaid Arrangements Made? ☐ Yes ☐ No (Please provide a copy.)

MILITARY SERVICE INFORMATION

A copy of the veteran's discharge or DD214 must accompany this application.

Wars Served In	**Discharge Type from Service**	**Branch of Service**	**If Dependent of a Veteran**
□ WWII □ Cold War □ Korean □ Persian Gulf □ Vietnam □ Iraqi Freedom □ Other □ Enduring Freedom	□ Honorable □ Medical □ Retirement	□ Air Force □ Army □ Coast Guard □ Marines □ Navy	□ Mother □ Father □ Widowed □ Spouse □ Former Spouse

Service Serial No.	VA Claim No.
Date of Entry into Active Duty	Separation Date
Residence at Time of Entry	
Place of Enlistment	Place of Discharge

Did a veterans' service organization assist you with your claim? □ Yes □ No

If yes, please provide name of organization: _____

INSURANCE INFORMATION

Medicare No. (if covered)	Part A Hospital □Yes □No Effective Date	Part B Medical □Yes □No Effective Date

Other Medical Coverage Claim No. □ Yes □ No	Name of Company Name of Insurance Carrier Address
Prescription Coverage Claim No. □ Yes □ No	Name of Company Name of Insurance Carrier Address
Dental Coverage Claim No. □ Yes □ No	Name of Company Name of Insurance Carrier Address
Vision Coverage Claim No. □ Yes □ No	Name of Company Name of Insurance Carrier Address

APPLICANT'S FINANCIAL DATA

This financial statement must be completed and signed by applicant, spouse, guardian or responsible person.
All questions must be answered. If the answer is none, put none.

PERSON HAVING FINANCIAL RESPONSIBILITY IF OTHER THAN APPLICANT

Name (Last, First, Middle)		Phone ( )	
Address (Street and Number)	City	State	Zip Code

Please check appropriate box: **NOTE: Please provide documentation for each box checked.**

□ Financially Responsible | □ Legal Guardian | □ Conservator | □ DPOA | □ POA | □ Patient Advocate

Occupation of Applicant	Last Date Worked
Former Employer	Years of Service
Former Employer	Years of Service
Automobiles(s) – Year and Make	

APPLICANT'S FINANCIAL DATA, Continued

MONTHLY INCOME	GROSS	NET
V.A. Disability Pension or Compensation	$	$
Social Security	$	$
Other Retirement Income (Source:)	$	$
Please list other income below:	$	$
1.	$	$
2.	$	$
3.	$	$
Rental Property Income	$	$
Land Contract Income (please provide a copy)	$	$
Dividends	$	$
Interest	$	$

Name and Address of Banks, Savings & Loan, Credit Unions	Type of Account: (please list) Savings, Certificate of Deposit (CD), Checking, IRA, Other	Amount
1.		$
2.		$
3.		$
4.		$
5.		$

Name of Life Insurance Companies	Beneficiaries	Amount
1.		$
2.		$

Are you or your dependents receiving, or will be receiving, long- or short-term nursing care insurance payments?

☐ **Yes** ☐ **No** **(If yes, please provide a copy)**

LOCATION OF REAL ESTATE

Street Address	City	State	Zip Code	Value
1.				$
2.				$

OTHER INVESTMENTS – IDENTIFY	
	$
1.	$
2.	$
3.	$
4.	$
5.	$

NOTE: Please provide past 3 years of federal income taxes if taxes were filed.

APPLICANT'S FINANCIAL DATA, Continued

Have you sold, transferred or created a joint tenancy (ownership) in any property within the last 36 months? (This includes cash and bank accounts.)

Applicant ☐ Yes ☐ No **Applicant's Spouse ☐ Yes ☐ No**

If yes, to (or with) whom:

Date of transaction: **In what amount:**

APPLICANT'S HISTORY

Have you ever been arrested or convicted of a felony? ☐ Yes ☐ No Of a misdemeanor? ☐ Yes ☐ No

If yes, please list all arrests and/or convictions:

Are you currently on parole/probation? ☐ Yes ☐ No

Although a disqualification is possible, a previous conviction does not automatically disqualify an applicant of consideration for residency at the Home. However, if an applicant fails to reveal any previous arrest and/or convictions, s/he shall be **disqualified** for admission.

If at any time after being admitted, it was found that there was misleading, false, concealed and/or omitted information pertaining to having been arrested or convicted of a misdemeanor and/or felony, then the resident shall be **immediately discharged** from the Home.

Please review your application and make certain that the information provided is accurate before placing your signature on this document acknowledging that all information provided is truthful and to the best of your knowledge.

I, _____, further depose and say that I will, if admitted to the Facilities, agree to notify the Grand Rapids Home for Veterans or the D.J. Jacobetti Home of all changes in benefits or estate. I further depose and say that the foregoing questions have been carefully read by me or to me, and that the answers I have given to the same are true to the best of my knowledge and belief. I fully understand and agree that, if I am admitted to the Home, I must abide by the laws of the State of Michigan pertaining to the Home and the rules and regulations of the Home and hereby agree to pay the balance of any funds accumulated while a member.

☐ Check this box to confirm agreement with the above statements.

_____

Applicant's Signature

Attachment No. 1 – Admission Application to Grand Rapids Home for Veterans

FINANCIAL STATEMENT FOR DEPENDENTS

FOR VETERANS OR APPLICANTS WITH DEPENDENTS ONLY

Applicants **WITHOUT** dependents, go on to Attachment No. 2

This financial statement must be completed and signed by applicant, spouse, or conservator.

All questions must be answered. If the answer is none, put none.

Spouse's Name: Date Last Worked:	Social Security Number:

INCOME SPOUSE AND/OR MINOR CHILDREN	MONTHLY INCOME	
	GROSS	NET
Wages (Source:)	$	$
Social Security	$	$
Other Retirement Income (indicate source below)	$	$
1.	$	$
2.	$	$
3.	$	$
Rental Property Income	$	$
Land Contract Income	$	$
Dividends	$	$
Interest	$	$
Other Income (indicate source below)	$	$
1.	$	$
2.	$	$
3.	$	$

Name and Address of Banks, Savings & Loan, Credit Unions	Type of Account: (please list) Savings, Certificate of Deposit (CD), Checking, IRA, Other	Amount
1.		$
2.		$
3.		$
4.		$
5.		$

Automobile(s) – Year and Make

Name of Life Insurance Companies	Beneficiaries	Amount
1.		$
2.		$

LOCATION OF REAL ESTATE

Street Address	City	State	Zip Code	Value
1.				$
2.				$

OTHER INVESTMENTS - IDENTIFY	Value
1.	$
2.	$

MONTHLY EXPENSES

LIVING EXPENSES AND INDEBTEDNESS	AMOUNT
Food and Clothing	$
Telephone	$
Electricity	$
Water & Sewage	$
Heat	$
Taxes	$
Home Insurance	$
Health Insurance (other than Medicare)	$

Life Insurance		$
Car Payments	Balance owed $ _____	$
Car Expense		$
Rent or Mortgage Payment		$
Other Expenses and Debts (indicate source below)		$
1.		$
2.		$
3.		$
4.		$
5.		$

DEPENDENT CHILDREN

DEPENDENT CHILDREN INCLUDE THOSE UNDER 18 YEARS OF AGE AND THOSE WHO, BECAUSE OF A DISABILITY, ARE STILL CONSIDERED DEPENDENTS

Name	Social Security Number	Birth Date	Source of Income (if any)	Amount
1.				$
2.				$
3.				$

MONTHLY MEDICAL EXPENSES

List All Medical Expenses (indicate source below)	Amount	Reimbursement Expected	Medical Costs Not Reimbursed	Balance Owed
1.				
2.				
3.				
4.				
5.				
6.				

Michigan Felony Statute False Pretenses

Michigan Compiled Laws Annotated Section 750.218 provides:

"Any person who shall by any false token or writing obtain from this State Institution care and services, the value of which exceeds $100 by intentional fraudulent misrepresentations or false signature before a notary shall be guilty of a felony punishable by imprisonment in state prison for a period not to exceed ten (10) years…"

It is unfortunate that a minority of veterans make false representations concerning their income and assets upon admission to this facility. This detracts from the services we are able to provide and increases the monthly costs to the honest veterans.

NOTICE AGREEMENT

For and in consideration of my admission to the Grand Rapids Home for Veterans, I hereby agree payment to the Board of Managers of the Facilities of any balance of money accumulated while a member of the Facilities, or due to me, or on deposit with any bank, trust company, corporation or with any individual, at the time of my death; provided all such sums shall be first expended to pay for residual maintenance costs attributable to the deceased individual, and shall then be paid to the spouse, minor children, or dependent mother or father in the order named.

If no such relative shall be found within a period of two years, or if no claim for the sums has been made within a period of two years, the balance of the money shall be paid into a fund in the hands of the Board of Managers of the Facilities to be expended by the Board of Managers to improve the service of the Facilities, pursuant to MCLA 36.61 as amended, P.A. 1905, No. 313.

I agree to notify the Grand Rapids Home for Veterans of any increases and decreases of income, assets, and expenses prior to the admission of this individual, and after his/her admission to the Grand Rapids Home for Veterans.

Signed by: (Please check one) ☐ Spouse ☐ Guardian ☐ Other responsible person

Name (printed) _____

Signature _____ Date _____

Attachment No. 2 – Admission Application to Grand Rapids Home for Veterans

PHYSICIAN'S CERTIFICATE

MEDICAL INFORMATION

The physician's certificate must be filled out and signed by the applicant's physician prior to the returning of this application.

Patient Name:	Date:	Smoker: ☐ Yes ☐ No

Current Diagnoses (if psychiatric, please attach recent assessment, progress notes, etc.)

_____

_____

_____

_____

Height _____ Weight _____ _____ Current Normal	Bed Sores ☐ Yes ☐ No If yes, where? _____ _____	Known Allergies (list) _____ _____ _____

Physician's orders and current medications. List method and frequency of actual administrations.
If diagnoses do not justify medications ordered, please explain.

Medication	Frequency	Diagnosis/Reason

DIET: ☐ Regular ☐ Diabetic ☐ Other _____

Unstable Medical Conditions:	

MEDICAL INFORMATION

Disabilities:	Impairments:	Activity Tolerance Limitations:
☐ Amputation ☐ Paralysis ☐ Contracture ☐ Wounds	☐ Speech ☐ Hearing ☐ Vision ☐ Sensation	☐ None ☐ Moderate ☐ Severe

Test: Date:	Immunizations: Date:	Special Diet:
Chest x-ray	Tetanus	Restrictions:
Lab work	Influenza Pneumonia TB Skin Test	Swallowing Problems:

Current Treatments:	Bed: Low Bed: ☐ Yes ☐ No Mattress: ☐ Regular ☐ Firm ☐ Specialty
Prognosis:	Oxygen Therapy: ☐ Yes ☐ No

Special Needs:	☐ Catheter	☐ Colostomy	☐ Tracheostomy	☐ Feeding Tube
	☐ IV	☐ Dialysis	☐ Fall Risk	☐ Latex Allergy

Indepen-dent	Needs Assist-ance	Unable to Do	Check level of self-care ability:
☐	☐	☐	Bathing
☐	☐	☐	Shaving
☐	☐	☐	Oral Hygiene
☐	☐	☐	Bladder Problem
☐	☐	☐	Bowel Problem
☐	☐	☐	Dressing Lower Extremities
☐	☐	☐	Dressing Upper Extremities
☐	☐	☐	Feeding
☐	☐	☐	Sitting
☐	☐	☐	Standing
☐	☐	☐	Walking Distance
☐	☐	☐	Wheelchair

Communication Ability:
- ☐ Can Speak
- ☐ Can Write
- ☐ Understands Speaking
- ☐ Understands Gestures
- ☐ Understands Writing

Appliances:
- ☐ Eyeglasses
- ☐ Dentures
- ☐ Partial/Flipper
- ☐ Hearing Aid(s)
- ☐ Prosthesis
- ☐ Crutches
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair

Behavior/Orientation/Special Psychosocial Needs (please check all that apply):

- ☐ Socially Inappropriate
- ☐ Disruptive Behaviors
- ☐ Combative
- ☐ Wanders
- ☐ Anxious
- ☐ Depressed
- ☐ Friendly
- ☐ Confused
- ☐ Long-Term Memory Problems
- ☐ Short-Term Memory Problems
- ☐ Inappropriate Behaviors
- ☐ Delusions
- ☐ Fearful
- ☐ Despondent
- ☐ Occasionally Confused
- ☐ Cooperative
- ☐ Special Psychosocial Needs
- ☐ Resistive to Care
- ☐ Hallucinations
- ☐ Suspicious
- ☐ Demanding
- ☐ Noisy
- ☐ Quiet
- ☐ Verbally Abusive
- ☐ Aggressive
- ☐ Withdrawn
- ☐ Angry
- ☐ Disoriented
- ☐ Alert

☐ Other: _____

APPLICANT MUST SUPPLY THE WRITTEN RESULTS OF A CHEST X-RAY TAKEN WITHIN 30 DAYS PRIOR TO ADMISSION AND A HISTORY AND PHYSICAL COMPLETED WITHIN THE LAST 90 DAYS.

EXAMINING PHYSICIAN

Signature	Date	Phone ( )	
Name (printed)			
Address	City	State	Zip Code

Signature of Person Completing Form: _____

Telephone Number: _____ Relationship to Applicant: _____